Arizona Health Care Cost Containment System

Arizona Department of Health Services

Children's Rehabilitative Services

Annual External Quality Review Report

for

Contract Year Ending 2013

Health Care Excel

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Introduction

The Children's Rehabilitative Services (CRS) Program provides a limited scope of services to children who have specific medical, disabling, or potentially disabling conditions that have the potential for functional improvement. The most common conditions are cerebral palsy, congenital circulatory problems, and congenital musculoskeletal deformities. Before the implementation of the AHCCCS program, CRS was known as the Society for Crippled Children. This society was founded in 1929 as a private charitable organization caring for poor children suffering from the effects of poliomyelitis and other conditions, such as club foot.

Children eligible for Arizona Health Care Cost Containment System (AHCCCS) are concurrently enrolled in an AHCCCS Acute Care or Arizona Long Term Care System (ALTCS) Contractor for their primary health care needs; and with UnitedHealthcare Community Plan-CRS (UHCCP-CRS) for the care of their CRS qualifying condition. As a result, AHCCCS children in the CRS program are enrolled in more than one managed care organization. Coordinating care for CRS members has been a long standing challenge for providers and a burden to families.

Prior to January 1, 2010, the CRS program was administered by the Arizona Department of Health Services, Office for Children with Special Health Care Needs (OCSHCN). Until that time, the Medicaid program and the CRS program were managed by separate state agencies. On January 1, 2010, AHCCCS entered into an Intergovernmental Agreement with ADHS to implement an administrative simplification of the CRS program. No changes were made that impacted the members, providers, or health plan, and full administrative oversight for the program became the responsibility of AHCCCS.

Effective October 2013, the CRS program will operate as a fully integrated health care system. CRS eligible children will be enrolled into one managed care organization (MCO) for their CRS, acute care, and behavioral health care needs. A single source of care is expected to increase the efficiency and effectiveness of the CRS program. UnitedHealthcare Community Plan will remain the MCO for the CRS program. Extensive planning to ensure a smooth transition to multiple new program requirements occurred during this contract year.

AHCCCS has a written Quality Assessment and Performance Improvement (QAPI) Strategy that complies with Balanced Budget Act (BBA) requirements. The quality strategy includes both the Medicaid and CHIP programs and encompasses AHCCCS acute and long-term care contractors, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS), and Children's Rehabilitative Services (CRS). The BBA requires an external quality review (EQR) of Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs). UHCCP-CRS is classified as a Managed Care Organization.

AHCCCS regularly monitors and evaluates access to care; organizational structure and operations; clinical and non-clinical quality measures; and performance improvement outcomes for all Medicaid

managed care contractors in Arizona, including UHCCP-CRS. Monitoring is accomplished through ongoing report and document review, regular meetings with UHCCP-CRS staff, and an onsite Operational and Financial Reviews (OFR) to evaluate compliance with federal and state requirements. On site reviews are conducted at least once every three years.

AHCCCS contracted with Health Care Excel (HCE) as the External Quality Review Organization (EQRO) to analyze findings and write the annual External Quality Review (EQR) report of the CRS program for Contract Year Ending (CYE) 2013. This review is limited to the three areas required in the Federal regulations: organizational assessment and structure performance, performance measurement performance, and performance improvement project performance. No optional EQR services are included in this report. AHCCCS uses the results of this EQR report to assess the effectiveness of the Quality Assessment and Performance Improvement (QAPI) Strategy; assist in the identification of strengths and opportunities for improvement; and to provide a roadmap for potential change.

SUMMARY OF FINDINGS

Organizational Assessment and Structure Performance

AHCCCS conducted an Operational and Financial Review of UnitedHealthcare Community Plan (UHCCP) Children's Rehabilitative Services (CRS) for all required federal and state standards in CYE 2011. Eighty-four (84) standards were reviewed and scored. UHCCP-CRS demonstrated Full Compliance with 82% of the standards. Fifteen standards required corrective action.

In CYE 2012, UHCCP-CRS completed ten of the fifteen required corrective actions and implemented the AHCCCS recommendations to two standards identified in the prior review. With the completion of the required corrective actions, UHCCP-CRS demonstrated full compliance with 93% of the 84 standards included in the AHCCCS Operational and Financial Review. Five standards continued to require corrective action. Three are related to Quality Management, one is related to claims interest payments, and one is related to encounter data reporting.

In CYE 2013 UHCCP-CRS revised policies, developed procedures, and submitted documents for review. AHCCCS reviewed and provided feedback on multiple drafts throughout the year. Final approval was pending at the time of this report. An Operational and Financial Review is planned for 2014.

Performance Measurement Performance

CRS recipients are included in the AHCCCS Acute Care or ALTCS population from which samples are drawn for Acute Care or ALTCS plan performance measures. Therefore, the standard performance measurement process established for Acute Care or ALTCS Contractors is not applicable to UHCCP-CRS. As a result, AHCCCS created performance measures that are unique to the CRS program and are reflective of the services provided by UHCCP-CRS. AHCCCS has defined the methodology to be used to measure performance, established a minimum performance standard, and a goal for each

performance measure. The three performance measures, the minimum performance standard, goal, and reported findings for CYE 2013 compared to CYE 2011 and CYE 2012 are displayed in **Table 1**.

Table 1: Comparison of Performance Measures with Standards and Goals

Performance Measure	Minimum Performance Standard	Goal	Compliance Rates		
			CYE 2011	CYE 2012	CYE 2013
Timeliness of Eligibility Determination	90%	98%	99.8%	99.9%	99.9%
Timeliness of Initial Service Plan Development	95%	100%	100%	100%	100%
Timeliness of First CRS Service	75%	90%	64%	68%	62%

UHCCP-CRS exceeds both the MPS and has met the Goal for two of the three required performance measures; timeliness of eligibility determinations and timeliness of an initial service plan development. The percent of children who receive their first CRS service by the date specified in their service plan or within 90 calendar days of eligibility is below the minimum standard and has dropped compared to the previous two years.

UHCCP-CRS has implemented many program changes, and initiated outreach and follow-up activities to improve the timeliness of the first CRS service during the previous two years. The improvement to be gained from these activities appears to have been maximized. Despite not meeting the goal for timeliness of the first CRS service, more than 88% of respondents to the CAHPS survey for Children with Chronic Conditions responded favorably to getting appointments with specialists and getting care, tests or treatment when needed. Member satisfaction with obtaining needed care right away and getting care quickly increased this contract year. It is possible that factors not related to network capacity are impacting performance on this measure. A re-evaluation of the root causes contributing to the long standing issues related to this measure should be performed.

AHCCCS is currently in the process of changing the Performance Measures to be used by the CRS program. The new measures will align with the clinical, outcome and satisfaction measures proposed by CMS. The new performance measures will become effective in October 2013.

Performance Improvement Project Performance

HCE reviewed the Electronic Health Information (EHR) Performance Improvement Project. The purpose of this Performance Improvement Project is to improve the number of laboratory test results uploaded into the EHR system within 90 days of the ordering visit for AHCCCS enrolled CRS members. CRS care is provided by a multi-disciplinary team of providers such as pulmonologists, cardiologists, social workers and nurse case managers. Because of the complexity of the needs of CRS children it is imperative that integrated health information be readily available to multiple providers. Historically, CRS attempted to coordinate care by restricting service to a limited number of locations where health records could be easily shared. In order to expand the number of clinical sites, and to better coordinate care, an easily accessible method of retrieving and sharing health information

must be available to a number of providers caring for the same child. An EHR would provide clinicians with timely access to health information and facilitate the sharing of health information among multiple providers caring for the same child. The literature suggests that EHRs can improve patient outcomes, reduce redundant services, medical errors and drug interactions. The PIP focuses on the development of system capability and its implementation along the following two dimensions:

- Capturing data elements and
- Making them available electronically to CRS providers at the MSICs

UHCCP-CRS identified that 28.3% of CRS recipients for whom at least one clinical laboratory test was ordered during the baseline year had documented evidence of test results in the electronic health record. UHCCP-CRS conducted a root causes analysis to determine the reasons why claims are not loaded into the EHR. Extensive analysis was performed and multiple problems were identified. Appropriate actions and interventions were implemented to correct identified problems and significant improvement was noted. At Remeasurement I, 70% of CRS recipients have clinical laboratory test results in the EHR within 90 days of the ordering visit compared to 28% at baseline. This far exceeds the goal of 40% for Remeasurement I and 50% at Remeasurement II. Because the interventions responsible for the improvements are primarily technical, and have been corrected, sustained improvement is anticipated.

I. BACKGROUND

Arizona's Medicaid program, known as AHCCCS, was established in 1982 and was the first Medicaid program in the United States to be granted an 1115 waiver. The waiver allows Arizona to operate a demonstration project using a managed care model for the delivery of health care services.

Prior to the implementation of the AHCCCS program, CRS was known as the Society for Crippled Children. This society was founded in 1929 as a private charitable organization caring for poor children suffering from the effects of poliomyelitis and other conditions, such as club foot. In 1935 the Social Security Act provided federal money to be used for the operation of this program. Today the program is known as Children's Rehabilitative Services.

CRS is a unique program that provides limited health care services to children under 21 years of age with certain chronic and disabling conditions. CRS services are provided by multiple specialists. Within CRS, the specialist who sees the child is not the primary care physician. It is important to note that all Medicaid eligible children, including those eligible under the State Children's Health Insurance Program (SCHIP) are assigned to an AHCCCS Acute Care or ALTCS Contractor for their acute, long term, and preventative health care needs. As a result, a child with complex health care needs is enrolled in a minimum of two separate systems of care. One for well-child and primary care, and the other for specialty care through CRS.

When a child is identified with a CRS covered condition, the child is referred to UHCCP-CRS. A child may be referred by a provider, parent, caregiver, or anyone involved with the child. If UHCCP-CRS determines that a child's condition qualifies for CRS coverage, the child is enrolled in the CRS program and must receive all care for that condition from the CRS contracted provider network. The provider network includes community providers and four regional Multi-Specialty Interdisciplinary Clinics (MSICS) that provide highly specialized and coordinated care to CRS members.

Each Medicaid eligible child in CRS is included in the Acute Care or ALTCS Contractor's PIPs and performance measures. Most of the PIPs and performance measures mandated by AHCCCS for the Acute Care/ALTCS Contractors are based on Healthcare Effectiveness Data and Information Set (HEDIS®) measures, such as immunization rates and well-child visits. These services are not covered benefits in the CRS program. AHCCCS has identified performance measures for the CRS Program and requires UHCCP-CRS to conduct PIPs relevant to the CRS program. CRS members are considered a special needs population and are included in the AHCCCS Quality Strategy.

AHCCCS has had a formal Quality Initiative and Performance Improvement Plan since 1994 and a Quality Strategy since 2003. It is reviewed annually and revised as appropriate. CHIPRA requirements were incorporated in 2010. The AHCCCS Quality Assessment and Performance Improvement Strategy is designed to ensure that services provided to members meet or exceed established standards for access to care, clinical quality of care, and quality of service. The Quality Strategy identifies and documents issues related to the quality standards and uses incentives, or requires corrective action to improve performance. The AHCCCS Quality Strategy complies with the format and content recommended by the Centers for Medicare and Medicaid Services (CMS). The

Quality Strategy encompasses AHCCCS acute and long term Contractors, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) and the Children's Rehabilitative Services (CRS) program.

The scope of the Quality Strategy as outlined by AHCCCS includes the following tenets:

- Enhance current performance measures, performance improvement projects, and best practices activities by creating a comprehensive quality of care assessment and improvement plan across AHCCCS Medicaid programs including CHIPRA that serves as a roadmap for driving the improvement of member-centered outcomes

- Build upon prevention efforts and health maintenance/management to improve AHCCCS members' health status through targeted medical management to include planning patient care for the special needs population

- Develop collaborative strategies and initiatives with state agencies and other external partners to include effective medical management of at risk and vulnerable populations

- Enhance customer service and improve information retrieval and reporting capability by establishing new and upgrading existing information technologies and thereby increasing responsiveness and productivity

Beginning October 2013, CRS members will be enrolled in one health plan for all of their CRS, acute care and behavioral health care needs. Medicaid services to CRS members will be fully integrated into one MCO (UHCCP). This single source of care will simplify the delivery of services, reduce duplication, and enhance coordination of care for CRS members.

II. DESCRIPTION OF EXTERNAL QUALITY REVIEW ACTIVITIES

Medicaid is a joint federal and state program that provides medical assistance to low-income groups including children, senior citizens, and people with disabilities. Since its inception in 1982, Arizona has operated its Medicaid program under an 1115 waiver. This waiver allows Arizona to use a managed care model to deliver health care services to its Medicaid population.

The BBA requires states to implement a quality assessment and improvement strategy and as part of that strategy, provide an annual external independent review of the quality, outcomes, timeliness of, and access to the services covered under each managed care contract.

Federal regulations require that the EQR include the following activities:

- Validation of PIPs required by the state to comply with requirements set forth in 42 CFR 438.240(b)(1) and that were underway during the preceding 12 months

- Validation of performance measures reported to the state or performance measures calculated by the state during the preceding 12 months to comply with requirements set forth in 438.240(b)(2)

- Reviews every three years to determine Managed Care Organization (MCO) and Prepaid Inpatient Health Plan (PIHP) compliance with standards required by the state to comply with 42 CFR 438.204(g), related to access to care, structure and operations, and quality measurement and improvement

These EQR activities may be performed by one or more organizations, but the findings must be incorporated into a single annual report prepared by one EQRO. AHCCCS contracted with HCE to prepare this CRS EQR Annual Report for Contract Year Ending (CYE) 2013. The annual report must include the following components:

- A detailed technical report describing the data aggregation and analysis and the way in which conclusions were drawn as to the quality, timeliness, and access to care;

- An assessment of each health plan's strengths and weaknesses with respect to quality, timeliness, and access to care;

- As the state determines, methodologically appropriate, comparative information about all health plans;

- Recommendations for improving the quality of health care services furnished by the health plans;

- An assessment of the degree to which each health plan has addressed effectively the quality improvement recommendations made by an EQRO during the prior year's EQR

AHCCCS is unique in its approach to EQR activities. AHCCCS has, over the past 25 years,

developed significant in-house resources, processes and expertise in monitoring its Managed Care contractors and performs the required quality review functions internally. AHCCCS provides its data and findings to the EQRO to analyze, summarize, and write the annual EQR report.

HCE based its review of the Organizational Assessment and Structure Performance on the information provided in the Operational and Financial Review (OFR) conducted by AHCCCS in CYE 2011, the limited OFR conducted in CYE 2012, and the follow up activities conducted in CYE 2013. HCE analyzed the findings and reviewed the corrective action plans, status updates, and revised policy documents to evaluate progress in CYE 2013. A description of the process used by AHCCCS is included in the Organizational Assessment and Structure Performance section of this report.

The performance measurement review is based on the rates submitted by UHCCP-CRS in its CYE 2013 Quality Management Program Evaluation. HCE analyzed the findings and compared them to findings from previous years. Corrective actions implemented by UHCCP-CRS to improve performance measures were reviewed and evaluated as part of the review process. A description of the process used by AHCCCS is included in the Performance Measurement Performance section of this report. A statistically significant random sample of recipient records to validate reported findings was not performed by AHCCCS this contract year.

HCE reviewed the Electronic Health Information Performance Improvement Project for Members Receiving Children's Rehabilitative Services. The information reviewed was provided by UHCCP-CRS as part of an annual report of its progress submitted to AHCCCS in its CYE 2013 Quality Management Program Evaluation. HCE analyzed the findings and compared two interim measures and one remeasurement to the baseline. A description of the process used by AHCCCS to review and approve PIPs is included in the Performance Improvement Performance section of this report.

AHCCCS uses the results of this EQR report to assess the effectiveness of the Quality Assessment and Performance Improvement (QAPI) Strategy; assist in the identification of strengths and opportunities for improvement; and to provide a roadmap for potential change.

III. STATE QUALITY INITIATIVES

In compliance with federal regulations, AHCCCS has a written QAPI Strategy designed to ensure that services provided to members meet or exceed established standards for access to care, clinical quality of care, and quality of service. This section of the report highlights the quality initiatives implemented by the state to support Contractor efforts to improve the quality of care and service provided to members, including those enrolled in the State Children's Health Insurance Program (SCHIP), known as KidsCare in Arizona.

As part of its QAPI Strategy, AHCCCS has identified specific goals and objectives as the focus of its strategy over the next five years. Many of the activities impact the CRS population. Highlights of the QAPI Strategy goals that impact the CRS program include the following.

- Enhance current performance measures, PIPs, and best practices activities by creating a comprehensive quality of care assessment and improvement plan across AHCCCS Medicaid programs that serves as a roadmap for driving the improvement of member-centered outcomes:

  - Fostering the increased resilience and functional health status of members with chronic conditions
  - Planning patient care for the special needs population
  - Improving functionality in activities of daily living
  - Exploring Centers of Excellence

- Develop collaborative strategies and initiatives with state agencies and other external partners. Objectives include:

  - Align and integrate the model for individuals with Serious Mental Illness (SMI), Children's Rehabilitative Services (CRS) and Dual-eligible members
  - Strategic partnerships to improve access to health care services and affordable health care coverage
  - Effective medical management of at risk and vulnerable populations
  - Capacity building in rural and underserved areas to address both professional and paraprofessional shortages

- Enhance customer service and improve information retrieval and reporting capability by establishing new and upgrading existing information technologies and thereby increasing responsiveness and productivity.

AHCCCS strives for optimal member health outcomes and member satisfaction. This is evidenced by the significant quality improvements that have been achieved, and those currently in progress. Highlighted below are some examples of recent accomplishments and current plans:

- **Performance Measures** – AHCCCS was among the first to utilize HEDIS® measures or HEDIS®-like measures for Medicaid managed care. Minimum Performance Standards (MPS) are based on the most recent national NCQA HEDIS® Medicaid means available. If the Medicaid mean for any measure is met, the MPS is based on a target to narrow the gap between the current AHCCCS statewide mean and a national goal such as Healthy People 2020. All Performance Measures apply to all member populations, but AHCCCS may analyze and report results by line of business/program, geographic services area (GSA) or county, and/or applicable demographic factors to identify opportunities for improvement. For example, rates for several child and adolescent members are analyzed and reported separately for Medicaid and KidsCare members, and further stratified by race/ethnicity.

  This system has helped achieve a high level of overall performance in several areas of preventive health, as measured by HEDIS® specifications. For example, the overall average of AHCCCS Contractors for annual dental visits by children and adolescents is in the top 10 percent of Medicaid health plans nationally. Other measures in which the AHCCCS program out performs the national average for Medicaid health plans are most measures of childhood immunizations and well-child visits in the first 15 months of life, appropriate medications for asthma and almost all KidsCare measures. Although HEDIS® measures are reasonable indicators of health care accessibility, availability and quality, thoughts on what is important to measure and how to measure have evolved and become more sophisticated. Focus has shifted from the importance of access to an office visit to the actual content of the visit: treatment of specific conditions, evidence based care, care coordination, care outcomes and patient safety.

  Going forward, AHCCCS is transitioning its Performance Measure requirements for all lines of business to align with the clinical, outcome, and satisfaction measures implemented by CMS. The CMS Core Measures include methodologies that utilize data sources and data collection processes that are not yet fully operational. In order to meet the technological demand of transitioning to a new performance measure set, AHCCCS is contracting with a vendor that is capable and interested in partnering to develop and implement measures from the CMS Core and other measures sets, in addition to maintaining the traditional HEDIS measures. Once completed, the transition is anticipated to result in greater availability of data/information that will allow for:

  - Increased efficiencies
  - Improved health care outcomes, including patient-specific outcomes
  - Improved patient satisfaction
  - Greater population health management capabilities
  - Reduced costs

- **Performance Improvement Projects** – The Agency has a well-developed process for identifying and conducting projects to improve performance in key areas of clinical care and non-clinical services that affect health outcomes and enrollee satisfaction. PIPs may be focused on specific populations or programs, and measurements for these projects may be stratified by line of business/program, GSA or county, and/or applicable demographic factors to identify opportunities for improvement.

In recent years AHCCCS has completed PIPs on improving asthma management, advanced directives, diabetes management, childhood immunizations and children's oral health. Successful outcomes include increasing the percent of elderly and physically disabled members with a documented advance directive from 41.8% to 64%; and decreasing the percent of members that refuse an influenza vaccine from 59.4% to 36.2%. In CYE 2013 mandated PIPs include reducing hospital readmissions, improving adolescent well care, use of electronic health records for the CRS population, and coordination of care between behavioral health and acute care contractors.

AHCCCS's commitment to continued performance improvement is evident and documented in its Strategic Plan for State Fiscal Years 2014-2018. The Plan includes a goal to increase the percent of AHCCCS contractors that demonstrate a statistically significant and sustained improvement on AHCCCS mandated Performance Improvement Projects.

- **Health Information Technology** – The Agency has been a strong leader in developing health information technology and exchange efforts since 2005, coordinating the first e-health summits, serving on the state roadmap development committees, and serving on the board of directors of the Arizona Health-e Connection, an e-health coordinating body that started in January of 2007.

  AHCCCS supports the adoption of certified EHR Systems as a tool to improve efficiency and effectiveness of patient data collection, clinical decision support and to provide accurate and reliable data for the purposes of outcomes measurement. AHCCCS is exploring a program to incentivize Medicaid and Medicare providers to adopt and meaningfully use EHRs. This is particularly important to improving the delivery of health care in a state like Arizona where many areas are classified as frontier and rural, with limited access to HIT resources.

  AHCCCS continues to serve on the Arizona Health-e Connection Board, which is focused on policy development and outreach and education to providers. AHCCCS is also a member of the Health Information Network of Arizona (HINAZ) Board, which won a state contract to build a provider directory and operate an HIE. AHCCCS has encouraged all of its health plans to join the HIE and expects services to start sometime in CYE 2013. Through the use of an approved IAPD from CMS, AHCCCS is helping to lower the cost of its high volume Medicaid providers to join HIE.

- **Increased Contractual Performance Standards** – AHCCCS has aligned its performance measures with the measure sets being implemented by CMS. In addition to identifying specific performance measures, AHCCCS includes a Minimum Performance Standard and Goal for each measure in its MCO and PIHP contracts. AHCCCS regularly monitors contractors to ensure compliance with the performance standards. In CYE 2011 AHCCCS began rewarding contractors that met 75% of the MPS on Clinical Quality Performance Measures by increasing their placement on the new member auto-assignment algorithm. In CY 2014 AHCCCS plans to implement a new payment structure that will reward contractors that meet the quality performance measures and reduce payments to contractors who do not meet the Minimum Performance Standards.

The focus of the AHCCCS strategy over the next five years is to increase the following measures:

- Percent of AHCCCS Contractors that meet the minimum contractual performance standards for Access to Care performance measures
- Percent of chronic care measures that achieve a statistically significant improvement for the integrated populations (CRS and SMI)
- Percent of AHCCCS Contractors that complete AHCCCS-mandated PIPs (improve and sustain performance) or demonstrate statistically significant improvement on remeasurements
- Percent of outcomes-focused quality performance measures (readmissions, inpatient days and emergency department utilization) that achieve a statistically significant state-wide improvement
- Percent of quality performance measures for the Medicaid population that achieve a statistically significant state-wide improvement

IV. BEST AND EMERGING PRACTICES FOR IMPROVING QUALITY OF CARE AND SERVICES

AHCCCS regularly shares best practices with, and provides technical assistance to, its Contractors and encourages them to share evidence-based best practices with each other and their providers. This is accomplished through sharing successful interventions during AHCCCS Contractor Quality Management/Maternal and Child Health; Medical Management; Medical Director; and Administrator meetings of which UHCCP-CRS is included. The following are examples of information shared at these meetings.

- UHCCP-CRS streamlined the eligibility and enrollment process for children enrolled with AHCCCS by eliminating the need for the applicant to see a CRS provider to confirm the qualifying diagnosis before enrollment. This allows children in need of CRS services to obtain them sooner. Earlier access to care may result in better outcomes.

- UHCCP-CRS successfully implemented a telemedicine program for orthopedic, neurology, metabolic and behavioral health services. Ninety-five percent of the families that used the service in CYE 2011 rated the experience as very good or excellent. Families reported that the wait time to see a doctor was shorter, and that on average they traveled 150 fewer miles, missed 10 fewer hours of work, and saved $166 by using the service. UHCCP-CRS continues to expand the service to improve access to sub-specialty care in rural areas and received a National Innovation Award for its efforts to close provider service gaps for CRS members living in remote areas of the Navajo Nation. The CRS telemedicine program was selected and competed with other national health plans and received a first place prize in technology from the Medicaid Health Plans of America (MHPA).

- UHCCP-CRS has established a Family Centered Cultural Competence Committee comprised of members/parents of diverse cultures; community advocacy groups; stakeholders and UHCCP-CRS staff that meet on a regular basis. This forum allows the entire community to have a voice in shaping relevant policy and programs.

- UHCCP-CRS heavily invested in the development and implementation of an electronic medical record. An electronic system to capture initial medical information at the time of application and the Service Plan for new CRS enrollees is currently available at the four multispecialty interdisciplinary clinic sites. UHCCP-CRS expects that using an electronic health record will allow providers to manage the complex medical conditions of the CRS population more efficiently and effectively. The system is continually evaluated to identify opportunities for improvement.

- UHCCP-CRS uses non-traditional healthcare workers such as promotoras to promote healthy behaviors and potentially ease the burden on the healthcare system.

- UHCCP-CRS is reaching out to the Indian Health Services and Tribal Health Departments to collaborate and contract with Tribal IHS/638 facilities to serve tribal members that seek care from both systems.

V. ORGANIZATIONAL ASSESSMENT AND STRUCTURE PERFORMANCE

A. Introduction and Objectives

The BBA requires Medicaid agencies that contract with Medicaid Managed Care Organizations (MCOs) and PIHPs to develop a state quality assessment and improvement strategy that is consistent with standards established by the Department of Health and Human Services (DHHS). AHCCCS has a written QAPI Strategy that complies with BBA requirements. The strategy was developed with input from AHCCCS members, the public, and other stakeholders. It is reviewed annually and/or when a significant change is implemented. The Quality Strategy is designed to ensure that services provided to members meet or exceed established standards for access to care, clinical quality of care, and quality of service. Federal requirements are broadly defined under the following categories.

- Enrollee Rights and Protections
- Quality Assessment and Performance Improvement
- Access Standards
- Structure and Operations Standards
- Measurement and Improvement Standards
- Grievance System

Federal regulations dictate that states perform a review of plan compliance with these standards at least once every three years. The objectives of this EQR are to determine to what extent UHCCP-CRS is in compliance with federal and state standards related to organizational assessment and structure and to identify areas where improvement and/or changes are needed. AHCCCS reports Quality Strategy activities, findings, and actions to AHCCCS members, other stakeholders, contractors, the governor, legislators, and CMS.

B. Description of Data Collection Methodology

AHCCCS uses a combination of methods designed to monitor and oversee UHCCP-CRS operations. On a regularly scheduled basis AHCCCS monitors and evaluates UHCCP-CRS compliance with access to care; organizational structure and operations; clinical and non-clinical quality measurements; and performance improvement outcomes through the following activities:

- Operational and Financial Reviews (OFR)
- Review and analysis of periodic reports
- Review and analysis of program specific performance indicators and PIPs

At a minimum of once every three years AHCCCS conducts an on-site review of UHCCP-CRS operations and finances. AHCCCS refers to these reviews as OFRs. The process used for these reviews has been refined over several years. A uniform tool is used to review each Contractor, although the tool used for the CRS program has been modified to reflect its unique scope of services. The format of the review follows nationally recognized processes and is modeled after NCQA Guidelines.

The Operational and Financial Reviews include document review, staff interviews, and observations of operations. This process is consistent with the protocol developed by CMS that includes the following recommended activities.

- Planning for the review
- Obtaining background information
- Document review
- Conducting interviews
- Collecting accessory information
- Reporting results

Upon completion of the OFR, key program areas are scored according to the following scale.

Full Compliance	90-100% agreement with standard(s)
Substantial Compliance	75-89% agreement with standard(s)
Partial Compliance	50-74% agreement with standard(s)
Noncompliance	0-49% agreement with standard(s)

A written report that includes findings and recommendations is produced. Recommendations are made based on the following definitions.

- "UHCCP-CRS must" – This indicates a critical noncompliance area that must be corrected as soon as possible to be in compliance with the AHCCCS contract.
- "UHCCP-CRS should" – This indicates a noncompliance area that must be corrected to be in compliance with the AHCCCS contract, but it is not critical to the everyday operation of the CRS program.
- "UHCCP-CRS should consider" – This is a suggestion by the review team to improve operations of UHCCP-CRS, although it is not directly related to contract compliance.

In addition to the OFR, the contract between AHCCCS and UHCCP-CRS contains a detailed list of periodic reporting requirements. The contract requires UHCCP-CRS to submit the following documents to AHCCCS for review or approval:

- UHCCP-CRS Policy Manual with copies of final policies submitted to AHCCCS at least ten business days prior to implementation
- Physician Incentive Plan disclosures
- All subcontracts for the provision of AHCCCS covered services
- Requests for proposals to provide AHCCCS covered services
- Legislative proposals and initiatives

Upon receipt by AHCCCS, the documents listed above are forwarded to the specific department within AHCCCS that has the expertise needed to analyze the content of the document. Where applicable, checklists have been developed for staff to use in the review process, ensuring that all required federal and state requirements are addressed. AHCCCS responds in writing, and either approves the document or requests revisions.

In addition, AHCCCS regularly obtains feedback from the Acute Care/ALTCS Contractors on CRS issues. The Acute Care/ALTCS Contractors are likely to be the first to know if CRS recipients or providers are having difficulty navigating the CRS system. These issues are reported to AHCCCS on an ongoing basis. Regular meetings with Medical Directors from the state's contracted health plans provides a forum to keep this dialogue open. The UHCCP-CRS Medical Director attends these meetings. In combination, these oversight activities provide AHCCCS with an accurate assessment of UHCCP-CRS compliance with state and federal requirements.

AHCCCS is unique in its approach to EQR activities. AHCCCS has, over the past 25 years, developed significant in-house resources, processes and expertise in monitoring its Managed Care Contractors and performs the required quality review functions internally. AHCCCS provides its data and findings to the EQRO to analyze, summarize, and write the annual EQR report.

C. Description of the Data

AHCCCS conducted an Operational and Financial Review of UnitedHealthcare Community Plan (UHCCP) Children's Rehabilitative Services (CRS) for all required federal and state standards in CYE 2011. Eighty-four (84) standards were reviewed and scored. UHCCP-CRS demonstrated Full Compliance with 82% of the standards. Fifteen standards required corrective action. UHCCP-CRS submitted, and AHCCCS approved, the required Corrective Action Plans.

In CYE 2012, UHCCP-CRS completed ten of the fifteen required corrective actions and implemented the AHCCCS recommendations to two standards identified in the prior review. With the completion of the required corrective actions, UHCCP-CRS is in full compliance with 93% of the 84 standards included in the AHCCCS Operational and Financial Review. Five standards continued to require corrective action. Three are related to Quality Management, one is related to claims interest payments, and one is related to encounter data reporting.

An Operational and Financial Review was not required or performed in CYE 2013. Monitoring activities focused on implementing and completing the corrective action plan. In response to required corrective actions, UHCCP-CRS submitted the following documents for review.

- Policy for *Credentialing/Recredentialing for Health Practitioners and Organization Providers;*
- Policy for *Quality of Care Investigation, Peer Preview, Improvement Action Plans and Disciplinary Actions*; and
- Desktop procedures for *Quality of Care Process, including Documentation, Evaluation, Resolution, Tracking and Trending*.

D. Conclusions: Strengths and Opportunities for Improvement

UHCCP-CRS demonstrated Full Compliance with 93% of the eighty four (84) federal and state standards reviewed by AHCCCS in CYE 2011/2012. Five standards required corrective action in CYE 2013. UHCCP-CRS revised policies, developed procedures, and submitted documents for review. AHCCCS reviewed and provided feedback on multiple drafts throughout the year. Final approval was pending at the time of this report. An Operational and Financial Review is planned for 2014.

VI. PERFORMANCE MEASUREMENT PERFORMANCE

A. Introduction and Objectives

As described in its QAPI Strategy, AHCCCS recognizes the need for identifying, tracking, and trending performance measures as a component of assessing the overall quality of care delivered to its members. AHCCCS recognizes that for these measures to be reliable and valid, the methodology must be sound and based on nationally recognized standards. AHCCCS uses HEDIS® to evaluate performance in its acute care plans. HEDIS® was developed by NCQA and is considered the national standard for measuring and reporting health plan performance.

In addition to identifying the performance measures, AHCCCS identifies a Minimum Performance Standard (MPS) and a Goal for each measure. The MPS and Goal for each measure are based on an objective methodology designed to "narrow the gap" between the current statewide average and a longer-range goal. If the MPS is not achieved, the contractor is required to develop and submit a corrective action plan with interventions aimed at meeting the MPS.

Medicaid eligible CRS members are enrolled in an Acute Care or ALTCS contractor for their primary health care needs. CRS members are included in the Acute Care or ALTCS Contractor population from which samples are drawn for the Contractor's HEDIS® performance measures. For example, when measuring immunization rates for two-year-old children, all of the two-year-olds are eligible to be included in the sample, including those receiving specialized services through CRS.

Since primary care performance is monitored for the Acute and ALTCS plans via HEDIS®, which focuses on preventive health care measures, HEDIS® is not applicable to CRS. Therefore, AHCCCS requires UHCCP-CRS to report performance on measures specific to the services provided by CRS. The performance measures and methodology used to measure performance are specified in the contract and must be reported and evaluated on an annual basis.

In CYE 2013, the following three access to care measures were required for CRS.

- Timeliness of Eligibility Determination
- Timeliness of Initial Service Plan Development
- Timelines of First CRS Service

These measures are reflective of the services provided by CRS. Due to the unique nature of these performance measures, there are no national standards or benchmarks that can be used for comparison. The purpose of these performance measures is to ensure that enrollees have access to care in a timely manner. Timely access to care is a proxy for network adequacy and is used as a way to evaluate if a health plan has enough providers to meet the needs of its members in a reasonable amount of time. AHCCCS has delineated the methodology to be used and established MPS and a Goal for each measure. **Table 2** identifies these requirements.

Table 2: Minimum Performance Standards and Goals

Performance Measure	Minimum Performance Standard	Goal
Timeliness of Eligibility Determination	90%	98%
Timeliness of Initial Service Plan Development	95%	100%
Timeliness of First CRS Service	75%	90%

The objective of the performance measurement validation is to determine if UHCCP-CRS is in compliance with the minimum performance standards as required by contract.

B. Description of Data Collection Methodology

The performance measures are defined as follows:

Timeliness of Eligibility Determination **--** The percent of AHCCCS members for whom a determination of eligibility was made (i.e., eligible or ineligible) and who were notified in writing of the decision within 14 calendar days of a complete CRS Referral Form received by the CRS subcontractor; or for whom a determination of eligibility could not be made from the CRS Referral Form and who were notified in writing within 14 calendar days of receipt of the Referral Form that additional information or a medical evaluation was required.

Timeliness of Initial Service Plan Development **--** The percent of AHCCCS members for whom an initial service plan (ISP) for CRS services was completed on or before the date of positive eligibility determination by the contractor.

First CRS Service **--** The percent of AHCCCS members who receive their first CRS service by the date specified on the ISP or within 90 calendar days of the date of positive eligibility determination.

The numerator and denomination criteria for each measure is defined in the contract. UHCCP-CRS collects the numerator and denominator data from the CRS clinic systems for all AHCCCS members who meet the denominator criteria and provides the information to AHCCCS in a predetermined electronic format. From the information submitted by UHCCP-CRS, AHCCCS identifies a statistically significant random sample of recipients who meet the numerator criteria and either requests from UHCCP-CRS the medical charts or other hardcopy documentation for validation purposes, or performs validation at site visits. The findings included in this report are limited to those reported by UHCCP-CRS.

C. Description of the Data

UHCCP-CRS's reported rates for each performance measure in CYE 2013 compared to CYE 2012 and CY 2011 are presented in **Table 3.**

Table 3: CRS Performance Measure Rates by Contract Year

Performance Measure	Compliance Rates by Contract Year		
	CYE 2011	CYE 2012	CYE 2013
Timeliness of Eligibility Determination	99.8%	99.9%	99.9%
Timeliness of Initial Service Plan Development	100%	100%	100%
Timeliness of First CRS Service	64%	68%	62%

UHCCP-CRS exceeds both the MPS and has met the Goal for two of the three required performance measures; timeliness of eligibility determinations and timeliness of an initial service plan development. The percent of children who receive their first CRS service by the date specified in their service plan or within 90 calendar days of eligibility is below the minimum standard and has dropped compared to the previous two years. UHCCP-CRS tracks performance on this measure by region. Timeliness of the first CRS service by region is displayed in **Table 4**.

Table 4: Timeliness of First CRS Service by Region (MISC)

Timeliness of First CRS Service by Region (MSIC) CY12/CY13										
Compliance Score	FLAGSTAFF		PHOENIX		TUCSON		YUMA		Total	
CYE	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013
Not Timely	45	52	944	996	156	153	18	14	1163	1215
Timely	249	205	1498	1193	570	460	123	131	2440	1969
First Service Total	294	257	2442	2169	726	613	141	145	3603	3184
Compliance Rate	85%	80%	61%	54%	79%	75%	87%	90%	68%	62%

Three of the four regional clinics meet or exceed the minimum performance standard for timeliness of the first CRS service. However, performance on this measure dropped at three of the four MSICs compared to CY2012. The Phoenix regional clinic that serves more than 68% of the CRS new member population has the poorest performance.

UHCCP-CRS initiated corrective actions to improve the timeliness of the first CRS service. Interventions were aimed at standardizing clinical activity to ensure ongoing monitoring for compliance and regularly meeting with staff to share findings and identify potential barriers to timeliness of the first CRS service. In addition, a program to call all new CRS enrollees within two weeks of enrollment was initiated. The purpose of the calls is to ensure that the enrollee received the required CRS information packet, answer enrollee questions, and ask if the first CRS visit has been

scheduled. If the first visit has not been scheduled, assistance with scheduling an appointment is offered. UHCCP-CRS continues to work on expanding telemedicine services for selected pediatric sub-specialties in rural areas where physician shortages may impact timeliness of services. UHCCP-CRS continues to authorize services outside of the CRS clinic sites when needed and tracks these services as a way to monitor network gaps. UHCCP-CRS believes these actions contributed to the improvement in the timeliness of the first CRS service reported in CY 2011/12.

D. Conclusions: Strengths and Opportunities for Improvement

UHCCP-CRS exceeded the MPS and has met the Goal for two of the three required performance measures in CYE 2013. The time it takes to get the first CRS service demonstrated significant improvement in CYE 2011 and CYE 2012, but dropped in CYE 2013. While three of the four regional clinic sites meet or exceed the minimum performance standard, performance dropped at three of the four clinic sites. The site with the greatest percentage of the membership performed the poorest.

UHCCP-CRS has implemented many program changes, and initiated outreach and follow-up activities to improve the timeliness of the first CRS service during the previous two years. The improvement to be gained from these activities appears to have been maximized. Despite not meeting the goal for timeliness of the first CRS service, more than 88% of respondents to the CAHPS survey for Children with Chronic Conditions responded favorably to getting appointments with specialists and getting care, tests or treatment when needed. Member satisfaction with obtaining needed care right away and getting care quickly increased this contract year. It is possible that factors not related to network capacity are impacting performance on this measure. A re-evaluation of the root causes contributing to the long standing issues related to this measure should be performed.

AHCCCS is currently in the process of changing the Performance Measures to be used by the CRS program. The new measures will align with the clinical, outcome and satisfaction measures proposed by CMS. The new performance measures have been incorporated into the UHCCP-CRS contract effective October 2013. Performance on these measures will be reported in the next EQR report.

VII. PERFORMANCE IMPROVEMENT PROJECT PERFORMANCE

A. Introduction and Objectives

PIPs are an important component of the overall AHCCCS QAPI Strategy. The requirement to design and implement PIPs is included in AHCCCS' contract with UHCCP-CRS and outlined in the AHCCCS Medical Policy Manual (AMPM) in Policy 980, Chapter 900.

AHCCCS' Medical Policy Manual complies with the CMS protocols for conducting PIPs. These protocols state that "The purpose of PIPs is to assess and improve processes, and thereby, outcomes of care. In order for such projects to achieve real improvements in care, and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted, and reported in a methodologically sound manner."

As required in 42 CFR 438.236, PIPs shall include the following components:

- Identify clinical or non-clinical areas for improvement
- Gather baseline data from administrative data and other sources
- Design and implement interventions
- Measure the effectiveness of the intervention
- Maintain and sustain the improvement

AHCCCS requires that a baseline measurement be collected and analyzed at the beginning of the PIP. During the first year of the PIP, the contractor is expected to implement interventions to improve performance based on an evaluation of barriers to care, use of services, and evidence-based approaches to improving performance, as well as any unique factors such as its membership, provider network, or geographic area(s) served. Contractors are expected to utilize a Plan-Do-Study-Act (PDSA) cycle, to test changes and interventions quickly and refine them as necessary. The PIP is expected to continue until significant improvement is achieved and sustained for one year.

AHCCCS requires all Contractors to submit a quality management plan and evaluation to report their interventions, analysis of interventions and internal measurements, changes or refinements to interventions, and results from repeat measures on an annual basis. Contractors are required to use the PIP Reporting Template developed by AHCCCS for this purpose.

AHCCCS must approve all PIP proposals prior to implementation. The approval process includes the following 10 activities from the CMS protocol for conducting PIP reviews:

1. Review the selected study topic(s)
2. Review the study question(s)
3. Review selected study indicator(s)
4. Review the identified study population
5. Review sampling methods (if sampling was used)
6. Review the MCO/PIHP's data collection procedures
7. Assess the MCO/PIHP's improvement strategies

8. Review data analysis and interpretation of study results
9. Assess the likelihood that reported improvement is "real" improvement
10. Assess whether the MCO/PIHP has sustained its documented improvement

In CYE 2013, HCE reviewed the Electronic Health Information (EHR) Performance Improvement Project. The objective of the review is to determine to what extent UHCCP-CRS is in compliance with the following:

- Measuring performance using objective quality indicators
- Implementing system interventions to achieve improvement in quality
- Evaluating the effectiveness of the interventions
- Planning and initiating activities to increase or sustain improvement

Electronic Health Information (EHR) Performance Improvement Project for Members Receiving Children's Rehabilitative Services.

The purpose of this Performance Improvement Project is to increase the number of laboratory test results uploaded into the EHR system within 90 days for AHCCCS enrolled CRS members who are either younger than 21 years of age and eligible under the Medicaid program (Title XIX of the Social Security Act) or who are younger than 19 years of age and enrolled in KidsCare (Title XXI)

B. Background

CRS care is provided by a multi-disciplinary team of providers such as pulmonologists, cardiologists, social workers and nurse case managers. Because of the complexity of the needs of CRS children it is imperative that integrated health information is readily available to multiple providers. Historically, CRS attempted to coordinate care by restricting service to a limited number of locations where health records could be easily shared. In order to expand the number of clinical sites, and to better coordinate care, an easily accessible method of retrieving and sharing health information must be available to a number of providers caring for the same child. An EHR would provide clinicians with timely access to health information and facilitate the sharing of health information among multiple providers caring for the same child. Use of an EHR is expected to increase the efficiency and effectiveness of the care provided to the CRS population. The literature suggests that EHRs can improve patient outcomes, reduce redundant services, medical errors and drug interactions.

UHCCP-CRS began work on the infrastructure needed to support the use of electronic health records with support from Title V resources and a grant from United Healthcare Foundation of Arizona. An electronic Service Plan and member enrollment application were implemented at the four multi-specialty, interdisciplinary clinics and evaluated for data accuracy, completeness and ease of use. Many data limitations were identified and providers reported that sharing the data was cumbersome and that they were not able to access the information in a timely manner. These findings prompted UHCCP-CRS to select electronic health records as the subject of its performance improvement project. UHCCP-CRS limited the scope of this PIP to laboratory data. The PIP focuses on the development of system capability and its implementation along the following two dimensions:

- Capturing data elements and
- Making them available electronically to CRS providers at the MSICs

C. Description of Data Collection Methodology

The study question is "What proportion of CRS recipients have clinical laboratory test results incorporated into the EHR within 90 days of the ordering visit?" The study question is clearly stated and answerable. The study indicator is "the number and percent of unique CRS recipients for whom clinical laboratory test results are incorporated into the EHR as structured data in a positive/negative or numeric format within 90 days of the ordering office visit." The study indicator is objective, measurable, and allows for the study question to be answered. The numerator and denominator for calculating the study indicator are identified.

All CRS enrollees with a minimum of one clinical lab test ordered during the measurement period are included in the study population. The data sources and the data collection methodology are described. All professional claims and encounters from lab vendors are unduplicated by member and date of service. A search for a match in the EHR is conducted to look for results associated with each test ordered. UHCCP-CRS staff audit a random sample of EHR data annually for completeness and validity. Data analysis is performed in accordance with the data analysis plan.

D. Description of the Data

In its annual PIP report submitted to AHCCCS, UHCCP-CRS reported the findings displayed in **Table 5**.

Table 5: The Number/Proportion of CRS Recipients with Clinical Lab Data in the EHR

Intervention Strategy Outcomes	Baseline Measurement CYE 2011	Interim Measurement CYE 2012	Remeasurement I CYE 2013
Lab data in EHR <90 days	28%	66%	28%
Lab data in EHR >90 days or not in EHR	72%	34%	72%

In CYE 2011, UHCCP-CRS identified that 28.3% of CRS recipients for whom at least one clinical laboratory test was ordered during the baseline year had documented test results in the electronic health record within 90 days. UHCCP-CRS conducted a root causes analysis to determine the reasons why claims were not loaded into the EHR. More than one problem was identified.

In CYE 2012, problems identified with laboratory vendor files were corrected and resulted in an increase in the percent of members with lab data in the EHR within 90 days. The rate increased from 28.3% at baseline to 43.5% after intervention strategies were initiated. While this represented a significant improvement, additional problems remained.

In 2013, an ID error with one of the major vendors was corrected. This resulted in an improvement from 43.5% to 66% of CRS recipients with clinical lab data in the EHR within 90 days after intervention

and continued to improve to 70% of CRS recipients with lab data in the EHR with 90 days at Remeasurement I.

E. Conclusions: Strengths and Opportunities for Improvement

UHCCP-CRS performed an extensive analysis of why the number and percent of CRS recipients for whom laboratory test results are incorporated into the EHR within 90 days of the ordering visit were significantly lower than anticipated. Appropriate actions and interventions were implemented to correct identified problems and significant improvement was noted. At Remeasurement I, 70% of CRS recipients have clinical laboratory test results in the EHR within 90 days of the ordering visit compared to 28% at baseline. This far exceeds the goal of 40% for Remeasurement I and 50% at Remeasurement II. Because the interventions responsible for the improvements are primarily technical, and have been corrected, sustained improvement is anticipated. However, UHCCP-CRS expressed concern that with recent technology advances, the use of data registries to transmit information, as defined in this PIP, have been replaced with newer options. UHCCP-CRS should explore newer technologies to advance the use of EHRs in its network.

VIII. CONCLUSIONS AND RECOMMENDATIONS FOR CHILDREN'S REHABILITATIVE SERVICES

Based on a review and analysis of the documents provided by AHCCCS, UHCCP-CRS meets the standards for quality, timeliness, and access to care as required under 42 CFR 438.204. Conclusions and recommendations for each required EQR activity are identified below.

Organizational Assessment and Structure Performance

UHCCP-CRS demonstrated Full Compliance with 93% of the eighty four (84) federal and state standards reviewed by AHCCCS in CYE 2011/2012. Five standards required corrective action in CYE 2013. UHCCP-CRS revised policies, developed procedures, and submitted documents for review. AHCCCS reviewed and provided feedback on multiple drafts throughout the year. Final approval was pending at the time of this report. An Operational and Financial Review is planned for 2014.

Performance Measurement Performance

UHCCP-CRS exceeded the MPS and has met the Goal for two of the three required performance measures in CYE 2013. The time it takes to get the first CRS service demonstrated significant improvement in CYE 2011 and 2012, but dropped in 2013. While three of the four regional clinic sites met or exceed the minimum performance standard, performance dropped at three of the four clinic sites. The site with the greatest percentage of the membership performed the poorest.

UHCCP-CRS has implemented many program changes, and initiated outreach and follow-up activities to improve the timeliness of the first CRS service during the previous two years. The improvement to be gained from these activities appears to have been maximized. Despite not meeting the goal for timeliness of the first CRS service, more than 88% of respondents to the CAHPS survey for Children with Chronic Conditions responded favorably to getting appointments with specialists and getting care, tests or treatment when needed. Member satisfaction with obtaining needed care right away and getting care quickly increased this contract year. It is possible that factors not related to network capacity are impacting performance on this measure. A re-evaluation of the root causes contributing to the long standing issues related to this measure should be performed.

Performance Improvement Project Performance

UHCCP-CRS performed an extensive analysis of why the number and percent of CRS recipients for whom laboratory test results are incorporated into the EHR within 90 days of the ordering visit were significantly lower than anticipated. Appropriate actions and interventions were implemented to correct identified problems and significant improvement was noted. At Remeasurement I, 70% of CRS recipients have clinical laboratory test results in the EHR within 90 days of the ordering visit compared to 28% at baseline. This far exceeds the goal of 40% for Remeasurement I and 50% at Remeasurement II. Because the interventions responsible for the improvements are primarily

technical, and have been corrected, sustained improvement is anticipated. However, UHCCP-CRS expressed concern that with recent technology advances, the use of data registries to transmit information, as defined in this PIP, have been replaced with newer options. UHCCP-CRS should explore newer technologies to advance the use of EHRs in its network.

APPENDIX

Documents Provided to Health Care Excel by AHCCCS for Use in the External Quality Review of UHCCP-CRS

1. AHCCCS/UHCCP-CRS Contract Amendment and Extension
2. UHCCP-CRS Quality Management Program Description for CYE 2013
3. UHCCP-CRS Annual Quality Management Evaluation for CYE 2013
4. UHCCP-CRS Quality Management Master Work Plan for CYE 2013
5. UHCCP-CRS UM/MM Program Description for CYE 2013
6. UHCCP-CRS UM/MM Program Evaluation for CYE 2013
7. UHCCP-CRS UM/MM Work Plan for CYE 2013
8. AHCCCS Strategic Plan for State Fiscal Years 2014-2018
9. AHCCCS Strategic Plan for State Fiscal Years 2013-2017
10. AHCCCS Quality Assessment and Performance Improvement Strategy 2012
11. AHCCCS Operational and Financial Review for CYE 2011 and CYE 2012
12. Corrective Action Plans Submitted by UHCCP-CRS in Response to the OFR Findings
13. QAPI Strategy Report
14. QAPI Program Contract & Medical Policy Requirements